

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-017830

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

4130

FILED APR 23 1963

VS 300
Rev. 4/59

1

2 2089

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12 90-0

13

90

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR TOWN

St. Louis

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR INSTITUTION

408 Blase

Inside Limits

Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Missouri

b. COUNTY

Inside Limits

Yes ☒ No ☐

c. CITY OR TOWN

St. Louis

d. STREET ADDRESS

(If outside, give location)

408 Blase

Reside on Farm

Yes ☐ No ☒

3. NAME OF DECEASED

(Type or print)

JOHN

First

H.

Last

KLEINE

4. DATE OF DEATH

Month

Day

Year

April 13th, 1963

5. SEX

male

6. COLOR OR RACE

white

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH

12/9/95

9. AGE (last birthday)

67

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

retired labourer

10b. KIND OF BUSINESS OR INDUSTRY

St. Louis, Mo

11. BIRTHPLACE (City and state or country)

USA

13a. FATHER'S NAME

Peter Kleine

13b. MOTHER'S MAIDEN NAME

Anna Kuntz

14. NAME OF HUSBAND OR WIFE

Marie Kleine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)

yes WW I 3097664

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Marie Kleine, 408 Blase

18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. ACCIDENT

☐

SUICIDE

☐

HOMICIDE

☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour

Month, Day, Year

a.m.

p.m.

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from Jan 10 - 63 to Apr 13 - 63 and last saw him alive on Apr 13 - 63

Death occurred at 7:15 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

John R. Morris M.D.

22b. ADDRESS

8054 9th Broadway

22c. DATE SIGNED

4/13/63

23a. BURIAL, CREMATION, REMOVAL (Specify)

removal

23b. DATE

4/17/63

23c. NAME OF CEMETERY OR CREMATORY

National Cemetery

23d. LOCATION (City, town, or county)

St. Louis Co., Mo.

(State)

24. FUNERAL DIRECTOR

ADDRESS

EMIL J. HEITZENROEDER, 8319 Hallsferry

25. DATE RECD. BY LOCAL REG.

APR 15 1963

26. REGISTRAR'S SIGNATURE

Earl Smith, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert M. Murray
Licensed Embalmer No. 2749

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.